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ABSTRACT

Some of the distinguishing features associated with behavioral prevention methodology are discussed. Behaviorists for Social Action have already implicitly identified target populations for preventive interventions, and the two distirct populations which have been identified can form the focus of preventive endeavors. The dissimilar populations are those individuals who are most at-risk for employment problems and those most at-risk for discriminatory hiring. Various research skills which behaviorists must acquire in order to competently initiate and evaluate prevention programs are enumerated: epidemiological research skills, experimental group design, statistics and measurement techniques, sampling techniques, assessment techniques, and psychometric principles. Finally, primary prevention represents the only approach which can effectively and comprehensively deal with critical social problems. (Author/BEF)

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Primary Prevention: The Only Course of Action

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Primary Prevention: The Only Course of Action

In various position papers presented at the 1978 organizational meeting of Behaviorists for Social Action, references were repeatedly made to the need for prevention programs. As the number of victims of social injustice increases, remediation of injustice on a case by case basis becomes progressively less feasible and the need for behaviorists to adopt a preventive orientation increases. In addition to being sensible and cost effective (Albee, 1979) preventive approaches possess great promise in promoting and insuring the well being of previously victimized populations.

In order to effectively institute and evaluate prevention programs, behaviorists must acquire certain skills which are currently not in their repertoire. The purpose of the present paper is to briefly discuss behavioral prevention as it relates to the Behaviorists for Social Action and to present some of the key skills which behaviorists must develop in order to make the transition to a preventive orientation.

The most widely accepted definition of prevention is presented by Caplan's (1964) concept of "primary prevention." Caplan describes three types of prevention: Attempts to prevent a disorder from occuring are referred to as primary prevention. Secondary prevention is aimed at identification and treatment at the earliest possible moment so as to reduce the length and severity of the disorder. Tertiary prevention attempts to reduce to a minimum the degree of handicap or impairment that results from a disorder that has already occured. As Wagenfeld (1972) has pointed out, secondary and tertiary prevention are synonymous to the more traditional terms of treatment and rehabilitation. Treatment denotes intervention after the onset of the disorder; and rehabilitation indicates an attempt to reverse the damage and to rebuild the systems that have been disrupted by the disorder.

The development, implementation, and evaluation of previous prevention programs have generally adhered to a common methodology. The first step is the identification of a target behavior or problem whose occurrence is to be prevented. Once the target behavior has been specified, epidemiologists collect data on the prevalence rate and on potential risk factors associated with the appearance of the disorder. Finally, a target population is selected. Preventive efforts may be directed to community-wide, milestone, or high-risk populations (Bloom, 1968). In community-wide prevention all residents of a community are the recipients of the program.

Milestone prevention refers to intervention directed toward critical development periods or situations; for example, immunizing preschool children for childhood diseases, providing birth control to adolescents, and providing pre-retirement counseling all constitute milestone prevention. Individuals currently in those situations constitute the milestone population.

While the focus in the milestone approach is on specific situations or events, high-risk programs are aimed at vulnerable populations. Groups vulnerable to specific disorders are identified and are subject to special programs designed to reduce or prevent the incidence of dysfunction. Upon selection of the target population, the prevention program is introduced and its effects examined after pre-determined time periods.

In one such example, primary prevention of coronary artery disease might be considered. Community-wide intervention or milestone intervention for those approaching middle age (since most individuals with coronary artery disease experience problems after age 40) could be effected. It is likely that epidemiological factors might indicate that treating an at-risk population is the most cost effective strategy.

After selecting the at-risk population to be treated, demographic factors associated with being at-risk should be indentified. A positive family history for heart disease, a high stress occupation, low exercise tolerance, smoking, and obesity would all contribute to being identified as at-risk. Then, specific variables which can control or moderate the factors placing the individual at-risk could be identified and combined into treatment plans.

Subsequent phases would include refinement of the intervention procedures, packaging the intervention, pilot interventions in one or more communities, and finally multi-community screening, implementation, and evaluation.

Behaviorists who are concerned with initiating constructive social change have already begun the type of prevention methodology just described, although the order of the components has differed from traditional prevention research. The first step has already been taken with the implicit identification of two at-risk populations: (1) minorities, the economically disadvantaged, and socially stigmatized groups are recognized as populations at high risk of being objects of social injustice, discrimination, etc. (2) A variety of individuals occupying positions of economic and social power might be deemed to be at-risk for engaging in inequitable social behavior.

Providing a precise operational definition for all forms of unfair social discrimination is a difficult, if not impossible task. However, many components of social injustice are easily identifiable and quantifiable as target behaviors. Unemployment and underemployment form only one example of a class of social problems which could be the focus of primary prevention. Behaviorists could focus on two dissimilar populations - those individuals who are most at-risk for employment problems or those individuals most at-risk for discriminatory hiring.

The first population could receive an intervention designed to facilitate the acquistion of skills and behaviors which will make the individual less susceptible to unemployment and underemployment. Such a prevention approach requires epidemiological work which will identify: (a) multiple prevalence rates of factors associated with the likelihood of being vulnerable to socially unjust hiring practices; (b) segments of the population and critical periods which are of the greatest risk for precursors to unemployment and (c) behaviors or skills which reduce the probability of the individual being victimized. For example, it may be determined that individuals of a certain at-risk ethnic minority possess adequate problem solving, coping skills, and vocational skills and who are not plagued by addictive behaviors are less suceptible to victimization. Therefore, a number of interventions would be introduced to prepare members of the target population for dealing with problematic (Spivack, Note 1) and stressful (Shigetomi and Barrios, Note 2) situations, and addictive substances (Marlatt, Note 3).

Treatment could be directed toward milestone prevention within at-risk groups to deal with the precursors of unemployment such as ill health, poor education, and lack of access to a job. Prevention could be inacted in the form of preschool education, remedial education and vocational planning in early adolescence, and job skills training and placement for the young adult. Finally; population wide programs might also be implemented within high risk communities.

Such preventive efforts need not impose the cultural values of the prospective employers on the treated populations. Prevention programs for impoverished and culturally different populations are often subjected to criticism for their implied assumption that deviations from the majority-group norms constitute some sort of deficit or inferiority (Ginsburg, 1972).

The thrust of prevention programs should be to maintain individuals' pride in their cultural heritage and to equip them with behavioral skills which will decrease the probability of experiencing problems in the physical, educational, psychological, vocational, and economic areas. Garcia and his associates (Garcia, Trujillo, and Batista, in press) have established a bilingual-bicultural nursery school for Chicano children. With consultation from psychologists, educators, and psycholinguists, the mothers determine the school curriculum and also teach the classes. Preliminary results indicate: 1) that the mothers use both Spanish and English in their instructions; 2) that they gain confidence in their teaching skills; and that the children do master the material presented in each intructional unit. This bicultural program strives to preserve cherished elements of the family's cultural backgournd while preparing the child for entry into conventional public schools. It exemplifies both milestone prevention for children who will avoid an early educational disadvantage and community-wide prevention for the Chicana mother, who receives useful teaching skills.

A second prevention approach might take a very different strategy to remediate social problems created by unemployment and underemployment. This approach might be directed toward populations at high risk of acquiring and exhibiting discriminatory and unjust hiring practices. Epidemiological research would be required in order to identify; (a) prevalence rates; (b) multiple factors connected with the probability of engaging in discriminatory hiring and (c) segments of the population and critical periods which are of the greatest risk for the development of the bases for socially inequitable behavior. Interventions would strive to facilitate acquisition of unbiased and just social behaviors. Modeling procedures (Bandura, 1977), cognitive behavior modification techniques (Cautela, Walsh, and Wish, 1971),

and dissemination of factual information (Farina, Fisher, Getter, and Fischer, 1978) could be utilized to accomplish these aims. Cautela and his colleagues, (Cautela, Walsh, and Wish, 1971; Cautela and Wisocki, 1969), for example, have improved attitudes towards retardates and the elderly by employing a covert reinforcement procedure.

In addition to effecting attitude change, a variety of incentives such as community purchasing power, monetary incentives for nondiscriminatory hiring and on the job training, and documentation of improved on-the-job performance would be likely to strongly affect hiring practices.

Primary prevention by behaviorists thus has a wide variety of applications through which social change can be instituted. The combination of primary prevention strategies and behavioral training may provide a unique combination of skills necessary to inact large scale social change.

Behavioral training has associated with it a number of aspects which should facilitate the execution of prevention work and the achievement of its goals (Hartmann, Shigetomi, and Barrios, Note 4; Peterson, Hartmann, and Gelfand, 1978). Among these are:

1. Behavioral techniques are based on sound, carefully developed procedures rather than on unproven, traditional clinical procedures and hunches. Typically behavioral techniques have gone through a series of laboratory tests or analogue conditions that insure their effeciency, or reveal their limitations.

2. Behaviorists' emphasis on design structure, procedural specification, and reliability assists in insuring that the behaviorally based techniques can be characterized, and procedures as well as results can be replicated.

3. Behavioral procedures are generally directed to clearly defined observable problem behaviors.

4. In most instances, the rationale and components of behavioral techniques can be easily comprehended by clients, and can be administered by moderately trained individuals or by the client him-or herself. Behavioral procedures meeting these requirements possess a monetary advantage over those traditional intervention techniques that require substantial professional time to administer.

5. Behaviorists tend to emphasize clinically significant and socially valid results. Critical aspects of clinical and social significance include the durability and generality of intervention effects, as well as the absence of undesirable side effects.

Despite the aforementioned strengths of behavioral training, behaviorists must acquire certain skills in order to effectively develop, implement, and evaluate prevention programs for large scale social problems. Behaviorists must become sophisticated with: (1) epidemiological research; (2) experimental and quasi-experimental group designs; (3) longitudinal methodology; (4) inferential and descriptive statistics; (5) the problems of statistical power; (6) sampling techniques; (7) discontinuous assessment; (8) psychometric principles; and (9) assessment instruments which lend themselves well to prevention research. Systematic implementation and evaluation of prevention programs require knowledge and expertise in these areas.

The present paper has discussed some of the unique aspects associated with behavioral prevention methodology; and has identified a number of research skills behaviorists should acquire. Remediation is an approach which Behaviorists for Social Action can ill afford to adopt. In order to efficaciously and comprehensively deal with the pressing social problems which confront society, primary prevention is the only course of action behaviorist can take.

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